

		FOR BHF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0010678</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																																																																															
<b>Facility Name:</b> <u>Winchester House</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/04</u> to <u>11/30/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																																																															
<b>Address:</b> <u>1125 North Milwaukee Avenue</u> <u>Libertyville</u> <u>60048</u>																																																																																	
<div>NumberCityZip Code</div>																																																																																	
<b>County:</b> <u>Lake</u>																																																																																	
<b>Telephone Number:</b> <u>(847) 377-7236</u> <b>Fax #</b> <u>(847) 816-5168</u>																																																																																	
<b>HFS ID Number:</b> <u>366006600</u>		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) _____</td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) _____</td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Andrew B. Cutler</u></td><td></td></tr><tr><td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td><td></td></tr><tr><td colspan="2" rowspan="2"><b>Date of Initial License for Current Owners:</b> <u>Before 1941</u></td><td colspan="2">(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr><tr><td colspan="2"><b>Type of Ownership:</b></td><td colspan="2"></td></tr><tr><td colspan="2"><table><tr><td><input type="checkbox"/></td><td>VOLUNTARY,NON-PROFIT</td><td><input type="checkbox"/></td><td>PROPRIETARY</td><td><input checked="" type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input checked="" type="checkbox"/></td><td>County</td></tr><tr><td colspan="2" rowspan="4">IRS Exemption Code _____</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other _____</td><td colspan="2"></td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2"><b>In the event there are further questions about this report, please contact:</b></td><td colspan="2"></td></tr><tr><td colspan="2"><b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u></td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		Paid Preparer	(Title) _____		(Signed) _____	(Date) _____	(Print Name and Title) <u>Andrew B. Cutler</u>		(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		<b>Date of Initial License for Current Owners:</b> <u>Before 1941</u>		(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		<b>Type of Ownership:</b>				<table><tr><td><input type="checkbox"/></td><td>VOLUNTARY,NON-PROFIT</td><td><input type="checkbox"/></td><td>PROPRIETARY</td><td><input checked="" type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input checked="" type="checkbox"/></td><td>County</td></tr><tr><td colspan="2" rowspan="4">IRS Exemption Code _____</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other _____</td><td colspan="2"></td></tr></table>		<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input checked="" type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input checked="" type="checkbox"/>	County	IRS Exemption Code _____		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	"Sub-S" Corp.			<input type="checkbox"/>	Limited Liability Co.			<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other _____					<b>In the event there are further questions about this report, please contact:</b>				<b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u>			
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Winchester House

# 0010678 Report Period Beginning: 12/01/04 Ending: 11/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>360</u>	Skilled (SNF)	<u>360</u>	<u>131,400</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>360</u>	TOTALS	<u>360</u>	<u>131,400</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,982</u>	<u>1,777</u>	<u>4,731</u>	<u>18,490</u>	8
9	SNF/PED					9
10	ICF	<u>69,716</u>	<u>14,087</u>		<u>83,803</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>81,698</u>	<u>15,864</u>	<u>4,731</u>	<u>102,293</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 77.85%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)

Employee Meals, Non-Resident Laundry, Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?

YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1941

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date                      NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number

of beds certified 46 and days of care provided 4,731

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL ☐ MODIFIED CASH\* ☒ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 11/30/04 Fiscal Year: 11/30/04

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/04 Ending: 11/30/05

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	1,298,091	54,629		1,352,720		1,352,720		1,352,720			1
2	Food Purchase		553,838		553,838		553,838	(34,600)	519,238			2
3	Housekeeping	958,324	44,153	(10,371)	992,106		992,106		992,106			3
4	Laundry	336,368	28,179		364,547		364,547	(20,788)	343,759			4
5	Heat and Other Utilities			632,533	632,533		632,533		632,533			5
6	Maintenance	701,084	93,801	185,483	980,368		980,368	(232,242)	748,126			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	3,293,867	774,600	807,645	4,876,112		4,876,112	(287,630)	4,588,482			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			20,147	20,147		20,147		20,147			9
10	Nursing and Medical Records	7,781,094	354,640	256,821	8,392,555		8,392,555		8,392,555			10
10a	Therapy	333,593	743		334,336		334,336		334,336			10a
11	Activities	425,278	10,983	1,926	438,187		438,187		438,187			11
12	Social Services	279,842	1,010	2,492	283,344		283,344		283,344			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	8,819,807	367,376	281,386	9,468,569		9,468,569		9,468,569			16
	<b>C. General Administration</b>											
17	Administrative	222,179			222,179		222,179		222,179			17
18	Directors Fees											18
19	Professional Services			50,775	50,775		50,775		50,775			19
20	Dues, Fees, Subscriptions & Promotions			42,262	42,262		42,262	(11,798)	30,464			20
21	Clerical & General Office Expenses	635,716	58,562	1,209,564	1,903,842		1,903,842	(8,888)	1,894,954			21
22	Employee Benefits & Payroll Taxes			3,831,663	3,831,663		3,831,663	886,881	4,718,544			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,162	17,162		17,162	(1,154)	16,008			24
25	Other Admin. Staff Transportation			3,686	3,686		3,686		3,686			25
26	Insurance-Prop.Liab.Malpractice			142,550	142,550		142,550		142,550			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	857,895	58,562	5,297,662	6,214,119		6,214,119	865,041	7,079,160			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	12,971,569	1,200,538	6,386,693	20,558,800		20,558,800	577,411	21,136,211			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							698,169	698,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,618	16,618		16,618		16,618			35
36	Other (specify):*											36
37	TOTAL Ownership			16,618	16,618		16,618	698,169	714,787			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	83,730	543,271	230,460	857,461		857,461	(196,518)	660,943			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,840	78,840		78,840	118,260	197,100			42
43	Other (specify):*	39,282	2,183	29,533	70,998		70,998	(70,998)				43
44	TOTAL Special Cost Centers	123,012	545,454	338,833	1,007,299		1,007,299	(149,256)	858,043			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	13,094,581	1,745,992	6,742,144	21,582,717		21,582,717	1,126,324	22,709,041			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(34,600)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(20,788)	04		8
9	Non-Straightline Depreciation	698,169	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,538)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,297)	20		28
29	Other-Attach Schedule	(395,503)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 239,443		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the  
general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	886,881		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 886,881		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ 1,126,324		37

\*These costs are only allowable if they are necessary to meet minimum  
licensing standards. Attach a schedule detailing the items included  
on these lines.

C. Are the following expenses included in Sections A to D of pages 3  
and 4? If so, they should be reclassified into Section E. Please  
reference the line on which they appear before reclassification.  
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Winchester Home			STATE OF ILLINOIS		Page 5A	
ID#			0010678			
Report Period Beginning:			12/01/04			
Ending:			11/30/05			
			Sch. V Line			
NON-ALLOWABLE EXPENSES			Amount	Reference		
1	Misc. Income	\$	8,880	21	1	
2	Bldg Tax (net in GL)		118,369	43	2	
3	Marketing		(19,046)	43	3	
4	Capitalized Repair and Maintenance		(34,282)	06	4	
5	Promotional		(169)	20	5	
6	Advertising		(3,794)	20	6	
7	Non-Allowable Seminar		(1,154)	24	7	
8	Pharmacy Inventory Adjustment		42,819	39	8	
9	Adult Day Care Expenses		(29,533)	43	9	
10	Adult Day Care Salaries		(23,419)	43	10	
11	Trx Capitalize Current Year Asset Additions		(197,960)	06	11	
12	Gain on Sale of Pharmacy Inventory		(230,375)	39	12	
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76					76	
77					77	
78					78	
79					79	
80					80	
81					81	
82					82	
83					83	
84					84	
85					85	
86					86	
87					87	
88					88	
89					89	
90					90	
91					91	
92					92	
93					93	
94					94	
95					95	
96					96	
97					97	
98					98	
99					99	
100					100	
101	Total		(395,503)		101	

## Summary A

11/30/05

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
County of Lake	100%					
See Attached Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	Unemployment Compensation	\$	County of Lake	100.00%	\$ 47,684	\$ 47,684	1
2	V	22	Workers Compensation		County of Lake	100.00%	496,285	496,285	2
3	V	22	FICA	858,375	County of Lake	100.00%	1,001,735	143,360	3
4	V	22	IMRF	1,049,125	County of Lake	100.00%	1,248,677	199,552	4
5	V	21	Indirect A&G Cost Allocation	1,195,394	County of Lake	100.00%	1,195,394		5
6	V	26	Liability Insurance	144,040	County of Lake	100.00%	144,040		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 3,246,934			\$ 4,133,815	\$ * 886,881	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT





## VIII. ALLOCATION OF INDIRECT COSTS

**Name of Related Organization** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City / State / Zip Code** \_\_\_\_\_  
**Phone Number** (        ) \_\_\_\_\_  
**Fax Number** (        ) \_\_\_\_\_

Fax Number ( )

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**



## VIII. ALLOCATION OF INDIRECT COSTS

**Name of Related Organization** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City / State / Zip Code** \_\_\_\_\_  
**Phone Number** (        ) \_\_\_\_\_  
**Fax Number** (        ) \_\_\_\_\_

Fax Number ( )

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**



## VIII. ALLOCATION OF INDIRECT COSTS

**Name of Related Organization** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City / State / Zip Code** \_\_\_\_\_  
**Phone Number** (        ) \_\_\_\_\_  
**Fax Number** (        ) \_\_\_\_\_

Fax Number ( )

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**

## VIII. ALLOCATION OF INDIRECT COSTS

**Name of Related Organization** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City / State / Zip Code** \_\_\_\_\_  
**Phone Number** ( ) \_\_\_\_\_  
**Fax Number** ( ) \_\_\_\_\_

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**

## VIII. ALLOCATION OF INDIRECT COSTS

**Name of Related Organization** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City / State / Zip Code** \_\_\_\_\_  
**Phone Number** ( ) \_\_\_\_\_  
**Fax Number** ( ) \_\_\_\_\_

Fax Number ( )

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6													6
7													7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.  
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.  
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2000

2001

2002

2003

2004

8

9

10

11

12

N/A

FOR OHF USE ONLY

13

14

15

16

FROM R. E. TAX STATEMENT FOR 2004

PLUS APPEAL COST FROM LINE 5

LESS REFUND FROM LINE 6

AMOUNT TO USE FOR RATE CALCULATION

\$

\$

\$

\$

13

14

15

16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winchester House COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0010678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

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A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 189,077 B. General Construction Type: Exterior Brick Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).  
Adult Day Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO  
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:  
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	522,720	Prior to 1941	\$ 5,466	1
2					2
3	TOTALS	522,720		\$ 5,466	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	360		1972	1971	\$ 5,306,095	\$		\$ 132,652	\$ 132,652	\$ 4,248,718	4
5			1960	1959	503,487					503,487	5
6	Adult Daycare Allocation			1971	(100,596)						6
7				1959	(9,545)						7
8											8
	Improvement Type**										
9	Various			1972	31,454		20	786	786	25,950	9
10	Various			1978	44,855		20	1,121	1,121	30,277	10
11	Various			1982	8,135		20	325	325	7,484	11
12	Various			1984	83,196		20	2,708	2,708	56,869	12
13	Various			1986	1,764,063		20	88,203	88,203	1,675,860	13
14	Various			1987	327,427		20	13,272	13,272	240,844	14
15	Various			1988	61,984		20	464	464	58,272	15
16	Various			1989	73,376		20			73,376	16
17	Various			1990	148,792		20	9,918	9,918	148,792	17
18	Various			1991	88,501		20	4,426	4,426	61,950	18
19	Various			1992	73,149		20	2,717	2,717	56,893	19
20	Various			1993	290,100		20	15,342	15,342	184,104	20
21	Various			1994	106,546		20	7,103	7,103	78,134	21
22	Various			1995	246,714		20	15,240	15,240	152,403	22
23	Various			1996	185,343		20	10,740	10,740	96,671	23
24	Various			1997	102,384		20	6,556	6,556	52,455	24
25	Various			1998	184,007		20	11,353	11,353	79,472	25
26	Various			1999	214,009		20	14,214	14,214	85,290	26
27	Various			2000	108,195		20	9,655	9,655	48,279	27
28	Various			2001	237,702		20	8,660	8,660	34,638	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total  
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)							67
68	Related Party Allocations (Pages 12-REP & 12A-REP)							68
69	Financial Statement Depreciation							69
70	TOTAL (lines 4 thru 69)	\$	10,079,373	\$		\$355,455	\$355,455	\$8,000,21870

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$10,079,373	\$		\$355,455	\$355,455	\$8,000,218	1
2	Hvac Bldg A Architect/Engr Fees	2002	1,924		20	128	128	385	2
3	Air Unit Bldg B	2002	2,550		20	170	170	510	3
4	Magnetic Doors	2002	1,962		20	131	131	392	4
5	Emergency Generator Final Pymt	2002	28,939		20	851	851	2,553	5
6	Magnetic Locks	2002	6,210		20	414	414	1,242	6
7	Plumbing	2002	784		20	39	39	118	7
8	Arch Fee - Sidewalk Project	2003	640		20	32	32	96	8
9	Emergency Panel	2003	3,389		20	169	169	508	9
10	Controller Unit On Doors	2003	7,988		20	399	399	1,198	10
11	Roll Thru Refrigerator	2003	7,000		20	350	350	1,050	11
12	Credit On Door	2003	(2,000)		20	(100)	(100)	(300)	12
13	Water Softener System	2003	9,995		20	500	500	1,499	13
14	Room #2105 Renovation	2003	2,879		20	144	144	300	14
15	Room #2107 Renovation	2003	2,879		20	144	144	300	15
16	Room #3105 Renovation	2003	2,879		20	144	144	300	16
17	Room #3107 Renovation	2003	2,879		20	144	144	300	17
18	Room #4105 Renovation	2003	2,879		20	144	144	300	18
19	Room #4107 Renovation	2003	2,879		20	144	144	300	19
20	Romm #5105 Renovation	2003	2,879		20	144	144	300	20
21	Room #5107 Renovation	2003	2,879		20	144	144	300	21
22	Elevator Valve	2003	2,700		20	135	135	383	22
23	Elevator Key Switch Circuit	2003	2,963		20	148	148	420	23
24	Engineer - Hvac	2003	4,780		20	239	239	498	24
25	Engineer - Roof Top Air Unit	2003	1,880		20	94	94	212	25
26	Grease Trap	2003	6,635		20	332	332	940	26
27	Electrician - Wiring	2003	960		20	48	48	100	27
28	Water Softener	2003	9,995		20	500	500	1,166	28
29	Architect - Lighting	2003	5,680		20	284	284	615	29
30	Flooring	2003	840		20	42	42	95	30
31	Flooring	2003	501		20	25	25	69	31
32	Flooring	2003	738		20	37	37	104	32
33	Plumbing	2003	702		20	35	35	91	33
34	TOTAL (lines 1 thru 33)		\$10,210,160	\$		\$361,609	\$361,609	\$8,016,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$10,210,160	\$		\$361,609	\$361,609	\$8,016,562	1
2	Service Sink	2003	722		20	36	36	105	2
3	Boiler Repair	2003	2,161		20	108	108	234	3
4	Built-In Closet Units	2003	15,021		20	751	751	2,128	4
5	Awning	2003	1,190		20	60	60	149	5
6	Door - Motor Gear Box	2003	790		20	40	40	99	6
7	Doors	2003	7,988		20	399	399	1,132	7
8	Doors	2003	1,693		20	85	85	240	8
9	Locks	2003	4,385		20	219	219	585	9
10	Carrier Air Handler	2003	173,602		20	8,680	8,680	18,084	10
11	Shelves	2004	9,773		20	489	489	611	11
12	Sidewalk Replacement	2004	37,295		20	1,865	1,865	2,486	12
13	Sidewalk Replacement	2004	12,475		20	624	624	780	13
14	Sidewalk Replacement	2004	12,350		20	618	618	720	14
15	Engineer - Roof Top Air Unit	2004	1,280		20	64	64	112	15
16	Staircase Railings	2004	5,770		20	289	289	457	16
17	Architect - Sidewalk Replacement	2004	9,630		20	482	482	602	17
18	Infrared Door Curtain Unit	2004	1,880		20	94	94	165	18
19	Elevator Repair	2004	517		20	52	52	99	19
20	Elevator Repair	2004	1,392		20	139	139	267	20
21	Elevator Repair	2004	522		20	52	52	100	21
22	Wall Bumpers	2005	406		20	20	20	20	22
23	Elevator Repairs	2005	1,980		20	99	99	99	23
24	Door Latches	2005	11,256		20	563	563	563	24
25	Door Latches	2005	2,989		20	149	149	149	25
26	Doors	2005	3,935		20	197	197	197	26
27	Doors	2005	2,485		20	124	124	124	27
28	Door Latches	2005	2,989		20	149	149	149	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,536,636	\$		\$378,057	\$378,057	\$8,047,019	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,866,277	\$	\$ 291,776	\$ 291,776	10	\$ 2,130,504	71
72	Current Year Purchases	71,359		7,136	7,136	10	7,136	72
73	Fully Depreciated Assets	35,327				10	35,327	73
74								74
75	TOTALS	\$ 2,972,963	\$	\$ 298,912	\$ 298,912		\$ 2,172,967	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		See Attached	2005	\$ 208,849	\$	\$ 21,200	\$ 21,200	5	\$ 104,085	76
77										77
78										78
79										79
80	TOTALS			\$ 208,849	\$	\$ 21,200	\$ 21,200		\$ 104,085	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,723,914	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 698,169	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 698,169	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,324,071	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BUILDING - 1960	\$ 180,634	\$	\$ 180,634	86
87	COMPUTER-MARKETING - 2005	1,639		164	87
88	COMPUTER-MARKETING - 2005	5,484		548	88
89	Adult Day Care - 2005	110,141			89
90					90
91	TOTALS	\$ 297,898	\$	\$ 181,346	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

9. Option to Buy:

YES

NO

Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES

NO
16. Rental Amount for movable equipment: \$ 16,618

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 80,341	\$		\$ 80,341	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			18,934			18,934	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			90,679			90,679	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 01	# of prescripts	83,730			543,271		627,001	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					40,506			40,506	13
14	TOTAL			\$ 83,730		\$ 230,460	\$ 543,271		\$ 857,461	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (192,570)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,078,495		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	83,028		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 968,953	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 968,953	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 197,975	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,074,476		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule			36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,272,451	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Attached Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,272,451	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (303,498)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 968,953	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 637,402	1
2	Restatements (describe):		2
3	See Attached	(597,731)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 39,671	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(343,169)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (343,169)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (303,498)	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/04 Ending: 11/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,646,313	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,646,313	3
	B. Ancillary Revenue		
4	Day Care	5,615	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,615	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	34,599	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	608,022	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	20,788	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 663,409	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,797	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,797	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,918,414	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,918,414	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,239,548	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	4,876,112	31
32	Health Care	9,468,569	32
33	General Administration	6,214,119	33
	B. Capital Expense		
34	Ownership	16,618	34
	C. Ancillary Expense		
35	Special Cost Centers	928,459	35
36	Provider Participation Fee	78,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,582,717	40
41	Income before Income Taxes (line 30 minus line 40)**	(343,169)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (343,169)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,909	3,057	\$ 77,404	\$ 25.32	1
2	Assistant Director of Nursing	2,112	2,112	84,651	40.08	2
3	Registered Nurses	57,501	64,476	1,998,759	31.00	3
4	Licensed Practical Nurses	19,047	22,411	623,463	27.82	4
5	CNAs & Orderlies	300,950	336,810	4,715,334	14.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,225	13,627	333,593	24.48	8
9	Activity Director					9
10	Activity Assistants	28,025	30,884	425,278	13.77	10
11	Social Service Workers	8,383	9,392	231,794	24.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	72,097	78,340	1,298,091	16.57	15
16	Dishwashers					16
17	Maintenance Workers	25,792	29,103	701,084	24.09	17
18	Housekeepers	60,536	67,535	958,324	14.19	18
19	Laundry	21,660	24,972	336,368	13.47	19
20	Administrator	2,110	2,151	142,814	66.39	20
21	Assistant Administrator	2,102	2,151	79,365	36.90	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,300	27,821	635,716	22.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,719	3,297	54,960	16.67	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	16,128	16,555	397,583	24.02	33
34	TOTAL (lines 1 - 33)	656,596	734,694	\$ 13,094,581 *	\$ 17.82	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	20,147	09-03	36
37	Medical Records Consultant	121	5,456	10-03	37
38	Nurse Consultant	20	4,000	10-03	38
39	Pharmacist Consultant	Monthly	3,780	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,926	11-03	44
45	Social Service Consultant	45	2,492	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	221	\$ 37,801		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,409	\$ 220,459	10-03	50
51	Licensed Practical Nurses	661	23,126	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,070	\$ 243,585		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Steve Nussbaum	Administrator		\$ 142,814	Workers' Compensation Insurance		\$ 496,285	IDPH License Fee	\$
Joan Bodenlos	Asst Admin		79,365	Unemployment Compensation Insurance		47,684	Advertising: Employee Recruitment	2,391
				FICA Taxes		1,001,735	Health Care Worker Background Check	2,700
				Employee Health Insurance		1,916,427	(Indicate # of checks performed 270 )	
				Employee Meals			Dues	675
				Illinois Municipal Retirement Fund (IMRF)*		1,243,221	Subscriptions	23,703
				Employee Relations		13,192	Licenses	995
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 222,179					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount			\$ 4,718,544		\$ 30,464
			\$				Less: Public Relations Expense	( )
							Non-allowable advertising	( )
							Yellow page advertising	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$ 1,076
Vendor/Payee	Type		Amount				St. Louis Seminar (allowable)	
FRR	Consulting		\$ 26,694				In-State Travel	67
ADL Data Systems	Computer		2,424					
QS1	Computer		3,131				Seminar Expense	14,865
MPA	Consulting		18,526					
							Entertainment Expense	( )
							(agree to Sch. V,	
							line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 16,008
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 50,775					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2)

Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount.

Yes  
LSN - \$14873
- (3)

Did the nursing home make political contributions or payments to a political action organization?  
If YES, have these costs been properly adjusted out of the cost report?

No
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period?

Yes  
10 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$106,724Line10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?  
If YES, give effective date of lease.

No
- (9)

Are you presently operating under a sublease agreement?

YESXNO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?  
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YESNONOX
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.  
This amount is to be recorded on line 42 of Schedule V.

\$197,100
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  
If YES, attach an explanation of the allocation.

No

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?  
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)  
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.  
Has any meal income been offset against related costs?

\$0  
YesIndicate the amount. \$34,600
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?  
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?  
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

c.

What percent of all travel expense relates to transportation of nurses and patients?

None

d.

Have vehicle usage logs been maintained?

Yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.

No
- (17)

Has an audit been performed by an independent certified public accounting firm?  
Firm Name:  
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?  
If no, please explain.

Yes  
Miller Cooper & Co  
No complete
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  
Attach invoices and a summary of services for all architect and appraisal fees.

N/A

SEE ACCOUNTANTS' COMPILATION REPORT